



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MELBURN K. HEUBNER, MD

Respondent Name

DEEP EAST TEXAS SELF INSURANCE

MFDR Tracking Number

M4-17-2909-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

JUNE 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I originally filed the claim for 9-6-2016 on 9-13-2016 according to my computerized ledger. As of today, the carrier claims they did not receive in a timely manner. I have attached all documentation I have. Dr. Huebner performed the services and I believe that it is only fair for him to get paid."

Amount in Dispute: \$225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation included with the providers bill received by the carrier on 4/20/17 referring to an invoice print out as proof of timely filing. This does not satisfy the requirements set down by TDI rule for certain exception for untimely submission of claim under Sec 408.0272."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 6, 2016	CPT Code 99213 Office Visit	\$115.00	\$0.00
	HCPCS Code L1902 Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated, off-the-shelf	\$90.00	\$90.00
	HCPCS Code A9300 Exercise equipment	\$5.00	\$0.00
	CPT Code 99080-73 Work Status Report	\$15.00	\$15.00
TOTAL		\$225.00	\$105.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires that in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be fair and reasonable.
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable
5. Neither party to this dispute submitted explanation of benefits to support the issue of dispute.

Issues

Is the requestor entitled to reimbursement for professional services rendered on September 6, 2016?

Findings

1. The respondent wrote that payment was denied based upon Section 408.0272 and timely filing the medical bill. A review of the submitted documentation finds that neither party to the dispute submitted copies of explanation of benefits to support that a timely filing issue was raised by the respondent during the audit process. 28 Texas Administrative Code §133.307(d)(2)(F) states in part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Because no documentation was presented to support that a timely filing issue was presented to the requestor prior to the date the request for MFDR, the timely filing issue will not be considered further in this decision.
2. The professional services in dispute are subject to the reimbursement guidelines set out in 28 Texas Administrative Code §134.203.
3. 28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."
4. CPT code 99213 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family." A review of the submitted medical report does not support 2 of the 3 key components to support billing CPT code 99213; therefore, reimbursement is not recommended.
5. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report

being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions."

A review of the submitted work status report finds the claimant was released to return to work without restrictions. This change supports billing for report per 28 Texas Administrative Code §129.5(d)(2). As a result, reimbursement of \$15.00 is recommended.

6. 28 Texas Administrative Code §134.203 (d)(1) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

Per DMEPOS fee schedule HCPCS code L1902 has a total allowable of \$94.88. Per 28 Texas Administrative Code §134.203 (d)(1), the MAR is $\$94.88 \times 125\% = \118.60 . The requestor is seeking a lesser amount of \$90.00; this amount is recommended for reimbursement.

7. HCPCS code A9300 does not have a relative value unit or payment rate assigned by Medicare or Medicaid; therefore, reimbursement for these services are set out in 28 Texas Administrative Code §134.203 (f).

28 Texas Administrative Code §134.203 (f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O) states the request for dispute resolution shall include: "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of \$5.00 for HCPCS code A9300 would be a fair and reasonable rate of reimbursement. As a result payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$105.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$105.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	06/28/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.